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ABSTRACT

This paper is intended to familiarize professionals involved in the treatment of the elderly with the role of the Psychologist Clinician as a member of the primary care health team. The paper provides a description of the care facility and its programmes, and of the areas of involvement of the Clinical Psychologist. Data regarding the number of cases referred and the various treatment programmes designed and implemented by the Psychologist are described to demonstrate the impact on patient care. Additionally, the role of the Psychologist Clinician as an aid to professional staff working with an older population is examined. The discussion serves to highlight the potential impact the Clinical Psychologist can have on patient care. Illustrations of new dimensions in patient treatment programmes, improved staff disposition, and staff training and education are provided as a basis for recommending wider utilization of this professional service in the care of the elderly. (Author)

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THE PSYCHOLOGIST CLINICIAN AND CARE OF THE ELDERLY

Ralph Shedletsky, Ph.D.

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THE PSYCHOLOGIST CLINICIAN AND CARE OF THE ELDERLY

Ralph Shedletsky, Ph.D. *

Introduction

Clinical psychologists practising their skills in the western world have increasingly assumed a more visible and professional profile to their colleagues and the public alike. Correspondingly, psychologists roles within industry, education, health and the like have blossomed. Within the scope of mental health, in particular, psychologists have gained recognition for their important contributions as individual practitioners and as responsible health team members.

Illustrations of the expanding areas of responsibilities are manifold. Consider, for example, a recent issue of The Ontario Psychologist (August, 1975) devoted to the theme of "Psychology in Medicine." Various papers describe the psychologist's function within the general hospital, industrial rehabilitation, treatment of physical diseases, and relationships with medical and other practitioners. Similarly, The Ontario Psychologist (August, 1976) devoted a later issue to the topic "A Multidisciplinary Phenomenon in the Mental Health Field," with further description of the services being offered and directed by practising psychologists.

Should one, however, examine this growth within the context of treatment of the older population, there is, sadly, a stark contrast. There are few general practitioners or specialists in psychology who pursue, or for that matter encourage, the older population as clientele. That is not to say that all psychologists follow this pattern. Indeed, educators, theorists and researchers, amongst others, have been actively involved in gerontology. Similarly, psychologists specializing in psychometrics provide significant services for the assessment and diagnosis of disturbances in older patients.

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Rather, this critique is addressed to that segment of psychologists who daily set out to help others improve their ability to cope, adjust and grow with life experiences so that they might attain a better quality of life. One might reasonably ask, where is the psychologist clinician, be he behaviourist, humanist, or analyst, when one enters the domain of the older person?

This paper cannot provide an adequate response to the question posed. However, what does follow is the description and discussion of a psychologist clinician role within a treatment centre for older patients. An attempt is made to demonstrate the need for, and utility of, such a role. Hopefully, others may therefore be encouraged to seek out and offer such services on a wider scale.

The Setting [1]

Sunnybrook Medical Centre is a University of Toronto teaching hospital which has within it an Extended Care Department consisting of 553 beds. Four hundred of these beds are classified as chronic and are housed in a new wing while 153 are domiciliary beds. Twenty-eight of these chronic beds are set aside for female patients with the remainder males. By agreement between the University of Toronto and the Department of Veteran Affairs, inpatient treatment is limited to entitled veterans until the need no longer exists. The average age of these patients is now 75 years. As well, Sunnybrook is situated demographically in an area with the highest proportion of the elderly in Metropolitan Toronto (in excess of 20%).

The Department of Extended Care contains specialized units which include an Assessment Unit, a Restorative Rehabilitation Unit, a Psychogeriatric Unit, a Self-care (Dominiliary) Unit, a Day Hospital, Long Term Care Units, Geriatric Consultation Clinics and Follow-up Clinics. Staffing consists of physicians, nurses, nurse specialists, occupational therapists, physiotherapists, speech pathologists, clinical pharmacists, social workers, and presently one psychologist.

In addition, students, interns and residents of various disciplines receive training within this department.

The aims of the Department of Extended Care are to return to, and keep in the community, as many patients as possible and to maintain the others in the best possible physical and mental health in the most suitable environment. Consequently, the Department has been actively attempting to change from a custodial care institution by extending existing programmes and developing innovative ones to meet the needs of the elderly patients.

The Psychologist Clinician's Role

At the request of the Department of Extended Care, the Psychology Department of Sunnybrook Medical Centre recruited the services of a full-time psychologist effective October, 1975. The job description for this position required that this individual be skilled in psychological assessment, treatment modalities, education and research.

(Appendix A)

Given the size of the Department of Extended Care and the expectations of above, the Department of Psychology agreed to provide psychometric as well as other supportive services in consultation with a psychologist clinician. In addition, faculty liaison with the Department of Psychology at a local university led to the utilization of graduate clinical students who would provide supervised services while undertaking training.

While the initial belief was that need for a psychologist would lie primarily with the psychogeriatric unit, the experiences of the last year have shown otherwise. Despite demarcation of a specific unit for psychologically disturbed older patients, it is, in retrospect, not surprising that patients and staff throughout the

department avail themselves of the service, demonstrating a greater need, and range, of psychological assistance than was first conceptualized. Accessibility to, and greater familiarity with, the psychologist's clinical skills undoubtedly contributed to this phenomena. Staff of all disciplines confessed to ignorance of the skills of a psychologist, beyond testing, but, to their credit, became eager pupils and subsequent consumers.

In effect, the specific activities of the past twelve months bear out the wide range of services offered. Instances will demonstrate this scope. Psychotherapy has been undertaken with individuals, couples and groups with ongoing sessions in many cases. Consultation has occured with individuals and groups of staff to assist in problem clarification and treatment design. The location of the psychologist's office within the Department of Extended Care facilitated informal discussions, important to the development of good communication and interaction with all staff. Participation in rounds and case conferences provided for formal input into patient care with all disciplines involved. The inservice education and training was provided to include a lecture series on psychiatric nomenclature and psychopathology, seminars on depression in the aged, and skill training in behaviour therapy and modification, assertion therapy and other treatment modalities. As well, a study group under the psychologist's chairmanship was initiated to consider palliative care for Extended Care patients.

Programme evaluation has been implemented with a reality orientation group for severely deteriorated inpatients. Behaviour charting, videotape and staff rating were incorporated to assess patient change within treatment. Similarly, a unique pub programme is being evaluated by investigating patient usage and feedback to determine its value. Finally, programme development, interdisciplinary cooperation and general concerns about patient care are subject matters of a multidisciplinary committee under the psychologist's chairmanship.

The Patient

The psychologist's role is formally one of a consultant. Although a great deal of contact is informally arranged, physicians are required to submit written requests for a patient to be seen. From these records the following data is forthcoming. In the last twelve months, 76 referrals were received for 65 patients, of which only three came from domiciliary care. The Psychogeriatric Unit (42%), the Assessment Unit (21%) and the Rehabilitation Unit (16%) accounted for 80% of the referrals with the remainder originating from Long Term Care Units.

The mean age of patients referred is 62.2 years (considerably lower than the mean for the department as a whole), with a range of 47 to 87 years. The vast majority of these cases had multiple physical and mental disturbances, including amputations, hemi and quadriplegia, arethrosclerosis, Korsakoff's syndrome, and the like. Psychological disturbance was therefore most often secondary to an underlying organic condition. While quite a few patients arrived with diagnoses of senile dementia, often these diagnoses were found to be inaccurate, with acute confusional states, alcohol related dementia, and severe depression accounting for the symptomatology.

The problems noted in referral requests can best be grouped into the following categories. 1) Behaviour management; this category includes problems in basic functions, e.g. eating, toileting, walking, abusive behaviour and motivation. 2) Alcoholism; this category involves patient abuse of alcohol within and outside of hospital. 3) Affective disturbance; in this category, mild to severe depression, by far the most prevalent affective disturbance, anger and hostility arise. 4) Marital or familial conflict; here spouses, families and significant others present as obstacles in patient care. 5) Mental status and intellectual functioning evaluation; this final category typically encompasses assessments of degree of

functional impairment arising from organic disturbances. Specifically, the question posed is usually, how well can this person be expected to function intellectually. With the exception of the latter category, referral requests most often expressed a need for advice in, or delivery of, treatment.

Treatment Approaches

The gerontological literature has long emphasized the importance of psychological factors in the overall well being of older patients. It is generally accepted that virtually any bona fide therapeutic approach will benefit these patients. While the therapeutic ventures described next were undertaken by the psychologist, this is not to suggest that other staff are not equally active in providing services.

With respect to the first category of problems encountered, the experience of this author and others, have supported the use of behavioural techniques as countermeasures to many debilitations of older, disabled and chronic patients. In an earlier paper (Shedletsky, 1976), this author reported on the use of behaviour modification and behaviour therapy with the Extended Care patients. Case examples cited instances of problematic eating behaviour (inability to use utensils thereby complicating an infectious disease), apathy and social isolationism (low motivation or refusal to partake in therapeutic and recreational activities), over-consumption of cigarettes, disturbing behaviour (chronic shouting for attention), incontinence of urine and feces, and refusal to assume independence of activities in daily living. In each of these instances, natural reinforcers in the patient's environment were utilized to establish a behavioural contingency plan whereby the patient could be encouraged and assisted to adopt more functional behaviour level. Similarly, instances of phobic conditions and anxiety neuroses were treated using deep muscle relaxation training as the precursor to desensitization of these fears, a behaviour therapy with long established efficacy.

The above cases demonstrated the feasibility of applying behavioural techniques to building new behaviours, to eliminate undesirable ones and to facilitate patient involvement in overall rehabilitative programmes. Perhaps as important as the resultant improved quality of life experienced by the patients themselves, was the impact on staff attitude and morale. Frustrated and demoralized by patients who could not and would not "do for themselves," staff were provided with a viable tool that promotes arrested deterioration, positive change, and consequently optimism that their efforts are needed and worthwhile.

As indicated earlier in this presentation, individual, couple and group psychotherapy have been undertaken. Approaches vary with the presenting problem. For example, patients describing alcohol abuse have responded to an understanding but firm approach. Therapy sessions served to allow the patient to discuss his feelings while at the same time to be subjected to control and monitoring of his drinking habits.

Anger, hostility and depression are prevalent emotions with the older institutionalized patients. Individual and group therapy offered opportunity to ventilate these feelings, to share with someone else their frustrations and disappointments, and to experience greater acceptance as a worthwhile being. For those individuals unable to arrive at expression of feelings, assertion training has been offered as a means of gaining release.

For many patients, progress in treatment and consequently duration and quality of stay in hospital are critically related to their status within marital or familial relationships. Prolonged absence, functional decline and need for support often isolate this individual and cause him to be rejected by significant others. This loss has in many cases been more devastating than physical or mental loss precipitating admission to hospital. Couple and family counselling has therefore emerged as a most urgent therapeutic intervention. Spouses and family members have been

brought together with the patient to dispel fears or any misconceptions, to offer aid in healing old wounds, to provide instruction in the care of the patient, and to otherwise encourage revitalization of their relationships.

These examples of therapy do not, of course constitute the whole of patient care. Rather, this intervention is most commonly addressed to obstacles lying in the path of patient recovery or stabilization. If unattempted, the patient may be abandoned as being without hope for change: if successful, the patient may more fully realize the benefit of the therapeutic services available for rehabilitation.

The Staff [2]

Staff attitude, morale, and expectation are repeatedly identified as critical factors in the care of patients. For this population, where the debilitation may be a long one, where life expectancy may be short, where outside support are minimal, and change is often for the worse, it is nothing less than a monumental task to maintain optimism, enthusiasm and self-satisfaction. There may be little forthcoming from which to derive the impetus required for high standards of care. The absence of established therapeutic means can render the staff as helpless and frustrated as the patients entrusted in their care.

Counter measures to problems inherent to those responsible for delivery of care have therefore emerged as significant factors in treatment programmes. One approach has been to provide staff with seminars and lectures to establish greater understanding for the psychological problems of the older person. A second has been to provide skill training, as with behavioural engineering, to lessen the sense of impotence often experienced. These have, nevertheless, often proven inadequate to deal with the complexities of staff deportment.

In response to the needs of staff working in the Extended Care facility, a therapeutic programme has been designed and implemented on the Psychogeriatric and

Assessment Units as pilot endeavours. Entitled simply "role-playing," staff meet with the psychologist bi-weekly for one-hour sessions. The goals of the meeting are to further their insight into others (patients, significant others, other staff) and into themselves, to allow them to ventilate their own pent-up feelings without fear of unwanted repercussions, to practice acceptable methods of emotional expression, and to collectively seek solutions to problems.

As the title would suggest, the major vehicle for meeting these objectives is role playing. Staff assume roles of patients, colleagues, and themselves and are encouraged to re-enact particularly troublesome experiences to allow for release of feelings. Subsequent discussion deals with insight development, and in some instances, problem solving. To date, staff have responded well to this approach and have indicated considerable satisfaction with the recognition given to the difficulty of their role and with the opportunity to cathect in a non-threatening milieu.

Discussion

It is difficult, when expounding on ones' own role and contribution in any endeavour, to differentiate between "what is" and "what could be." Undoubtedly, the foregoing discussion constitutes a mixture of both. This should not, however, invalidate the intent of this presentation, which was to introduce or familiarize people with the potential impact the psychologist clinician can have on patient care through direct and indirect means.

This presentation is addressed to psychologists as much as to other professionals. Psychologists have been equally neglectful in providing services for the elderly as have been hospitals, homes and other settings in seeking them out. Hopefully, highlighting the utility and productivity of the role of the psychologist clinician will help to counteract this neglect.

As well, it is important to recognize and restate that the role described herein cannot exist on its merits alone. To be effective, the psychologist clinician must operate within the context of a team approach, willing and able to share experience and knowledge with other professionals. Only then can his unique contribution be realized in a meaningful way.

FOOTNOTES

1. This section is extracted from reports prepared by Dr. R. Fisher, Head, Department of Extended Care, Sunnybrook Medical Centre.

2. This section is based, in part, on a segment of a paper read at the Ontario Psychogeriatric Association Annual Meeting, Ottawa, September, 1976.

REFERENCES

Shedletsky, R. Behaviour Modification and the Older Person: A Case Study. Paper read at the Ontario Psychogeriatric Association Annual Conference, Ottawa, September, 1976.

APPENDIX A

PSYCHOLOGIST CONSULTANT TO EXTENDED CARE

The psychologist consultant to Extended Care is a member of the Psychology Department and directly responsible to Head of the Psychology Department.

Assessment:

- accepts referrals from treatment team in Extended Care for intellectual, personality, neuropsychological and other testing relevant to patient treatment and rehabilitation

- writes reports on assessment results and conveys results to referral source and nursing when appropriate

- evaluates patient abilities and personality for placement in appropriate programmes

- makes recommendations from patient assessment for patient treatment

- evaluates programmes in Extended Care

- evaluates and makes recommendations on a wide variety of patient/staff, patient/patient, patient/environmental problems

- co-operates with the multidisciplinary team in Extended Care

- accepts a limited number of referrals from other hospital departments for geriatric assessment

Treatment:

- plans individual and group programmes in rehabilitation, re-orientation, re-motivation, behaviour modification etc.

- implements programmes with the co-operation of the multidisciplinary team

- institutes and conducts individual and group counselling

- provides counselling to patient relatives when appropriate

- acts as a consultant with respect to general problems of treatment, physical or psychosocial

- accepts a limited number of referrals from other hospital departments related to geriatric treatment programmes

Teaching:

- supervises graduate students in psychology assigned to Extended Care

- participates in in-service teaching programmes

- is involved with community resources and educational programmes for patient relatives

Research:

- acts as a consultant on research design, statistics, measurement, etc.

- initiates and funds practical research on psychological problems associated with geriatrics

QUALIFICATIONS

PSYCHOLOGIST CONSULTANT TO EXTENDED CARE

- Doctor of Philosophy (Clinical Psychology)

- Registration or registration pending

- Experience in geriatric settings or equivalent

- Experience designing and instituting programmes directed at patient treatment and rehabilitation

- Experience with ward and individual operant learning programmes

- Assessment experience

- Group and individual counselling experience

- Interest and enthusiasm in geriatric problems

- Ability to work as part of a multidisciplinary team